



THE INDIVIDUALIZED SUPPORT PLAN

State Form ()

NOTE: When completing this form electronically, use your computer's TAB key to navigate the fields.

THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Name of Individual _____ Social Security # _____

☐ Female ☐ Male

Name of Facilitator _____ Date of ISP _____

Medical Insurance _____

☐ Initial ☐ Revised

Individual's Personal and Demographic Information

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

DOB _____ RID# _____ Legal Status _____

Current Living Arrangement: _____

The Individual is currently ☐ In School ☐ Employed ☐ Other (Specify _____)

Individual's Diagnosis

PRIMARY _____ SECONDARY _____

Individual's Emergency Contacts

Name _____ Phone # _____ Relationship _____

Address _____
If Relationship is "Other", Specify: _____

Alternate contact method _____

Name _____ Phone # _____ Relationship _____

Address _____
If Relationship is "Other", Specify: _____

Alternate contact method _____

Name _____ Phone # _____ Relationship _____

Address _____
If Relationship is "Other", Specify: _____

Alternate contact method _____

Name _____ Phone # _____ Relationship _____

Address _____
If Relationship is "Other", Specify: _____

Alternate contact method _____

❖ Attach Person Centered Planning Profile Information



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Name of Individual _____
Date of Support Plan _____

Outcome towards which this Individualized Support Plan will work

Desired Outcome

Current Status

Past Experiences

Proposed Strategy/Activity

Responsible Party

Time Frame

Progress Note

Outcome ____ of ____



Name of Individual _____

Date of Support Plan _____

Desired Outcome
<p>1. The patient will be able to identify the signs and symptoms of a stroke.</p> <p>2. The patient will be able to describe the risk factors for a stroke.</p> <p>3. The patient will be able to explain the importance of taking medications as prescribed.</p> <p>4. The patient will be able to demonstrate proper use of assistive devices.</p> <p>5. The patient will be able to perform self-care activities independently.</p> <p>6. The patient will be able to communicate effectively with family and healthcare providers.</p> <p>7. The patient will be able to manage stress and maintain a positive attitude.</p> <p>8. The patient will be able to participate in community activities and social interactions.</p> <p>9. The patient will be able to follow a healthy diet and exercise regimen.</p> <p>10. The patient will be able to recognize and seek help for mental health concerns.</p>

Current Status	
Project A	On Track
Project B	Delayed
Project C	On Track
Project D	On Track
Project E	On Track
Project F	On Track
Project G	On Track
Project H	On Track
Project I	On Track
Project J	On Track
Project K	On Track
Project L	On Track
Project M	On Track
Project N	On Track
Project O	On Track
Project P	On Track
Project Q	On Track
Project R	On Track
Project S	On Track
Project T	On Track
Project U	On Track
Project V	On Track
Project W	On Track
Project X	On Track
Project Y	On Track
Project Z	On Track

Past Experiences

<u>Proposed Strategy/Activity</u>	<u>Responsible Party</u>	<u>Time Frame</u>	<u>Progress Note</u>

Outcome of



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Outcome ____ of ____



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Date of

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Statement of Agreement

I have been involved in the development of my Individualized Support Plan and I agree with this Plan.

I know I can appeal to the DDARS if I disagree with how this plan is put into action.

Signed _____ Date _____

Individual for whom this plan was written

date signed

Signed _____ Date _____

Guardian of Individual, if applicable

date signed

Individualized Support Plan Participants

Participant	Relationship	Date plan was sent	Sent via
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax
			<input type="checkbox"/> E-mail <input type="checkbox"/> Postal Mail <input type="checkbox"/> Telephone <input type="checkbox"/> In Person <input type="checkbox"/> Fax



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Meeting Issues and Requirements

Comments boxes will expand to accept text

The Individualized Support Plan team shall check any of the following Health and Behavioral Issues that may concern the individual and explain how they are met or addressed by this plan.

	Comments
<input type="checkbox"/> If a Provider is needed to provide health and behavioral support (Name the provider responsible)	
<input type="checkbox"/> Seizures, or History of Seizures	
<input type="checkbox"/> Allergies, or History of Allergies	
<input type="checkbox"/> Uses or Requires Dentures	
<input type="checkbox"/> Chewing Difficulties	
<input type="checkbox"/> Swallowing Difficulties	
<input type="checkbox"/> Dining Difficulties	
<input type="checkbox"/> Vision Difficulties	
<input type="checkbox"/> Hearing Difficulties	
<input type="checkbox"/> Speaking Difficulties / Mode of Communication	
<input type="checkbox"/> Behavior Issues	
<input type="checkbox"/> Issues discovered through review of Incident Reports	
<input type="checkbox"/> Medication/Self Medication Issues	
<input type="checkbox"/> Lab Testing	
<input type="checkbox"/> Other chronic conditions or healthcare issues	

<input type="checkbox"/> Regular family physician	
<input type="checkbox"/> Dentist	
<input type="checkbox"/> Specialist (seizures, mental health issues, etc.)	



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Meeting Issues and Requirements

Comments boxes will expand to accept text

The Individualized Support Plan Team must show which of the following Safety and Environmental Requirements have been met by this Plan, and how.

Comments

- ☐ If a Provider is needed to provide environmental and living arrangement support (Name provider responsible)
- ☐ Carbon Monoxide Detectors
- ☐ Smoke Detectors
- ☐ Emergency Phone Numbers
- ☐ Emergency Evacuation Routes and Plan
- ☐ Fire Extinguishers
- ☐ Insurance
- ☐ Anti-Scalding Devices
- ☐ Devices and Home Modifications
- ☐ Personal Emergency Response System
- ☐ Current Photograph in Personal File
- ☐ Transportation
- ☐ Individual's Property/Financial Resources (Name provider)

The Individualized Support Plan Team must show which of the following Provider Requirements have been met by this Plan, and how.

Comments

- ☐ 1st Case Manager contact after ISP implementation
- ☐ Frequency of Case Manager monitoring visits
- ☐ Maintaining individual's personal file (Name provider)
- ☐ Analyzing and updating of records (Frequency)
- ☐ Frequency at which Individual is informed of
 - ☐ Medical Condition
 - ☐ Developmental Status
 - ☐ Behavior Status
 - ☐ Risk of Treatment



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Optional Attachment: Resources

This individual is currently receiving funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

If Individual is receiving
Waiver funds, which Waiver? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

The team and the individual discussed funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ All Medicaid Waivers

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual does not desire funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual has applied for funding support from the following sources:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments:

This individual is currently on a waiting list for the following supports:

☐ DFC ☐ BDDS ☐ DOE Wrap-Around ☐ Voc. Rehab. ☐ CHOICE ☐ Medicaid Waiver

Which Waiver(s)? _____

☐ SSI ☐ SSDI ☐ Medicaid ☐ Medicare ☐ Trust Fund ☐ Employment Earnings

Other / Comments: